DR. IKE'S PHARMACY
ADVANCED SPECIALTY PHARMACY

OSTEOARTHRITIS
REFERRAL FORM

Fax: **888.804.7717**

Ship To: ❑ Patient ❑ Physician/Clinic Date Shipment Needed: _____ **Rx**: ❑ New ❑ Refill _____

PATIENT INFORMATION

Patient's Full Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alt. Phone: _____

Patient SS#: _____

DOB: _____

Allergies: _____

Gender: ❑ Male ❑ Female

Primary Insurance: _____

ID#: _____ Phone: _____

Secondary Insurance: _____

ID#: _____ Phone: _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Diagnosis: ❑ 715.0 Osteoarthritis ❑ _____

Date of Diagnosis: _____

Home Health Coordination

Specialty Pharmacy to coordinate home health nursing visit as necessary. ❑ YES ❑ NO

Agency of choice: _____ Date of Administration: _____

Home health nursing coordination is not necessary.

Reason: ❑ MD office administered ❑ Home health nursing already coordinated

Has patient received previous treatment with hyluranidase? ❑ YES ❑ NO

Does the patient skin diseases or infection in or around the affected joint? ❑ YES ❑ NO

If patient has tried simple analesics, please name and include strength and duration:

_____

Has patient received previous treatment with hyluranidase? ❑ YES ❑ NO

If yes, how long ago? _____ months

Did patient experience pain relief? ❑ YES ❑ NO

Does the patient have extensive inflammation with joint effusion or an inflammatory flare?

❑ YES ❑ NO

Has the patient been treated with simple analgesics in the past? ❑ YES ❑ NO

Unilateral or bilateral treatment? ❑ Unilateral ❑ Bilateral

Patient Weight: _____ kg/lbs

Concomitant Medications: _____

Allergies: _____

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ Euflexxa	❑ 20mg/2ml Prefilled Syringe	❑ Inject contents of prefilled syringe inta-articularly once a week for 3 weeks ❑ Include one 20G 1.5" needle per syringe ❑ Other: _____ ❑ Left Knee ❑ Right Knee ❑ Bilateral		
❑ Hyalgan	❑ 20mg/2ml Prefilled Syringe ❑ 20mg/2ml Vial	❑ Inject contents of prefilled syringe/vial inta-articularly once a week for ___ weeks ❑ Include one 20G 1.5" needle per syringe/vial ❑ Other: _____ ❑ Left Knee ❑ Right Knee ❑ Bilateral		
❑ Orthovisc	❑ 30mg/2ml Syringe	❑ Inject contents of prefilled syringe inta-articularly once a week for _____ weeks ❑ Include one 20G 1.5" needle per syringe ❑ Other: _____ ❑ Left Knee ❑ Right Knee ❑ Bilateral		
❑ Supartz	❑ 25mg/2.5ml Prefilled Syringe	❑ Inject contents of prefilled syringe inta-articularly once a week for 5 weeks ❑ Include one 23G 1.5" needle per syringe ❑ Other: _____ ❑ Left Knee ❑ Right Knee ❑ Bilateral		
❑ Synvisc	❑ 16mg/2ml Prefilled Syringe	❑ Inject contents of prefilled syringe inta-articularly once a week for 3 weeks ❑ Include one 20G 1.5" needle per syringe ❑ Other: _____ ❑ Left Knee ❑ Right Knee ❑ Bilateral		
❑ Arixtra				
❑ Fragmin				
❑ Lovenox				
❑ Other				

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI#: _____

Address: _____ License#: _____

City, State, Zip: _____ DEA#: _____

Phone: _____ Fax: _____ Contact Name: _____

Physician's Signature: _____ Date: _____

I authorize Dr. Ike's Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.